ADVANCE HEALTH CARE DIRECTIVE GUIDE AND FORM

Planning for Future Health Care Decisions

Beebe Healthcare

Effective Date

SEPTEMBER 2025

Dear Friend of Beebe Healthcare,

Thank you for choosing to complete this Advance Health Care Directive! You are actively protecting your right to have a 'voice' in your care, especially when your family is facing difficult medical decisions. We have found the guidance our patients provide in advance directives to be very valuable, for us and for family members. We are glad you agree.

The 2025 Uniform Health Care Decisions Act includes significant changes to the old Delaware law, responding to the current needs of Delawareans and their healthcare professionals. This packet includes these changes. When completed, give copies of the form to your Agent, your healthcare providers, family members, clergy, and others who may be involved in your care. Meaningful conversations with these people will help everyone to be prepared.

We encourage you to learn as much about advance directives as possible. A helpful guide is included in this information packet. If you have a question or would like assistance completing your advance directive, contact the Beebe Patient Advocate at 302-645-3547. You can contact the Division of Aging at 800- 223-9074, 302-391-3505 (TDD) or DelawareADRC@state.de.us, or you may consult your personal attorney. Beebe Healthcare has formal policies on advance directives available for review.

Beebe Healthcare encourages generosity through organ and tissue donation, please contact Gift of Life Donor Program at 800-366-6771 or visit their website at www.donors1.org for more information.

We applaud you for taking the initiative to create an advance directive. At Beebe Healthcare we believe that our best patient is an informed and prepared patient.

Sincerely,

Katie Johnson DO
Chair, Bioethics Committee

ADVANCE HEALTH CARE DIRECTIVE GUIDE

INFORMATION ABOUT YOUR RIGHT TO DECIDE YOUR CARE

Who decides what health care I get?

As a competent adult with decision-making capacity, you have the legal right to make your own health care decisions, and you have the right to receive this information in a way you can understand. Your Physician, Advance Practice Clinician, or another health care professional advise you and make recommendations about treatment, but you have the authority to say "yes" or "no" to any treatment that is offered to you.

What if my medical condition leaves me unable to decide?

If a medical condition causes you to lose the capacity to understand medical choices and make informed decisions, someone else must make decisions for you. If you are at least 18 years old, you may make a written "Advance Health Care Directive" to name the person who will act as your agent and make decisions for you. The directive can also provide guidance to your agent, your Physicians or Advance Practice Clinicians so they understand what you want or do not want when you are unable to decide yourself.

What is included in an Advance Health Care Directive?

Under Delaware law there are three sections to an Advance Health Care Directive:

- Power of Attorney for Health Care
- A list of Priorities for care planning
- Instructions for the use of life-sustaining treatments.

A **Power of Attorney for Health Care** (Medical Power of Attorney) allows you to name another person as an **Agent** to make health care decisions for you if your medical condition makes you unable to do so. You can appoint any adult over the age of 18 to be your agent. However, Delaware law places the following restrictions:

- A court finds that the potential agent poses a danger to the patient's well-being, even if the court does not issue a Protection from Abuse order against the potential agent.
- The potential agent is an owner, operator, employee, or contractor of a nursing home or long-term care facility in which the patient resides or is receiving care, unless the owner, operator, employee, or contractor is a member of the patient's family, a cohabitant of the patient, or a descendant of the patient.
- The patient has a pending Protection From Abuse petition against the potential agent.
- The patient has a Protection From Abuse order against the potential agent.
- The potential agent is the subject of a civil or criminal order prohibiting or limiting contact with the patient.

The **Instruction for Health Care Decisions** is a written statement of your intentions. It includes your instructions for treatments when you are terminally ill, permanently unconscious, or suffer from serious illness or frailty.

To create an Advance Health Care Directive, you must be capable and competent to make health care decisions. An adult witness must watch you sign and then add their signature to the directive.

You must choose a witness who is an adult, but who is not the person you are naming as your Agent, the Agent's spouse, domestic partner, or someone the Agent lives with as a couple. If you are in a hospital, nursing home or similar facility, you must choose a witness who is not an employee of the facility.

Does an Advance Health Care Directive apply when I am pregnant?
Delaware law provides that life-sustaining procedures cannot be withheld or withdrawn from a pregnant patient, so long as it is probable that the child will develop to the point of live birth.

Where should I keep my Advance Health Care Directive?
You should keep the original in an easy to find place and give copies to your Agent, your Physician or Advanced Practice Clinician, and your local hospital, so it will become part of your medical record. You can also give copies to close family and friends, your lawyer, and your clergy, anyone who may be involved in supporting your choices.

What if I change my mind?
You can revoke your Advance Health Care Directive at any time by destroying it, or by making a new one. You should also inform your Physician, Advance Practice Clinician, and your Agent.

Will my Advance Health Care Directive be valid in another state?
State laws vary, but generally, medical professionals strive to honor other states' directives. If you move to another state, you should make a new advance directive in that state. If you have a valid advance directive from another state, it will be valid in Delaware to the extent it is consistent with Delaware law. Updating to the most recent Delaware Advance Health Care Directive may be a good choice.

What happens if I do not have an Advance Health Care Directive?
In the absence of a patient's written designation of an Agent or having named a Surrogate verbally, or if the Agent or Surrogate is not reasonably available, any member of the following classes of the people associated with the patient and who is reasonably available, in the following order of priority, may act as a Default Surrogate:

1. The spouse or domestic partner, unless any of the following are in effect.
    - A petition for annulment, divorce, dissolution of marriage, legal separation, or termination has been filed and not dismissed or withdrawn.
    - A decree of annulment, divorce, dissolution of marriage, legal separation, or termination has been issued.
    - The patient and spouse or domestic partner have agreed in a record to a legal separation.
    - The spouse or domestic partner has deserted the patient for more than one year.
2. An adult child or parent.
3. A cohabitant.
4. An adult sibling.
5. An adult grandchild or grandparent.
6. An adult who has assisted the individual with supported decision making routinely during the previous six months, and who is not one of the people identified above.
7. A stepchild whom the patient actively parented during the stepchild's minor years and with whom the patient has an ongoing relationship.
8. An adult who has exhibited special care and concern for the patient and is familiar with the patient's personal values.
9. If no qualifying close friend is available, a guardian may be appointed by the Court.

COMPLETING THE FORM

You should read this form carefully before filling it in. You should fill it in completely. If there are health care decisions you do not want to make, draw a line through the wording rather than leave it blank. You may not change the qualifications for your agents or the witness who signs with you, even if you cross out the wording. Please write legibly.

Keep the original copy of your Advance Health Care Directive and give other copies to your Physician or Advanced Practice Clinician, Agent, Spouse, family members, clergy and close friends if you desire. You should explain why you made the choices you made to each person who receives a copy. Sharing this information will help the people who care about you honor your health care values and goals.

This form does not contain all types of health care decisions you are legally entitled to make. For example, this form does not give you the opportunity to nominate a guardian in the event you become incompetent and need one. If you would like to nominate a guardian, you should talk to an attorney.

To confirm that your choices are consistent with the teachings of your religious body, you should contact your clergy.

If you have chosen to be an organ and tissue donor, offering the gift of life to others, please inform your Agent. If you would like to know more about the potential benefits of organ and tissue donation and learn about the Gift of Life Donor Program, please call 1-800-DONORS1, (800-366-6771) or visit http://www.donors1.org.

COMPLETING PART I: POWER OF ATTORNEY FOR HEALTH CARE

Your agent may make any health care decision that you could have made while you had the capacity to make health care decisions, including the use of life sustaining treatments. You are strongly encouraged to appoint an alternate agent to make health care decisions if your first agent is not willing, able, or reasonably available to make decisions. (See the list of agent qualifications in the "Power of Attorney for Health Care" definition in the previous section.)

Unless you indicate otherwise, your agent will be authorized as follows:

- To consent to, refuse, or withdraw consent to all types of medical care, treatment, surgical procedures, diagnostic procedures, medication, and the use of mechanical or other procedures that affect any bodily function, including the use of life sustaining treatments.
- To access medical records and information to the same extent that you are entitled, including the right to disclose the contents to others,
- To authorize your admission to or discharge from any hospital, nursing home, residential care, assisted living or similar facility or service,
- To contract for any health care related service or facility on your behalf, without your agent incurring personal financial liability for such contracts,
- To hire and fire medical, social service, and other support personnel responsible for your care; and
- To authorize, or refuse to authorize, any medication or procedure intended to relieve pain, even though such use may lead to physical damage, addiction, or hasten the moment of (but not intentionally cause) your death.

Your agent will make health care decisions for you by following the priorities and instructions in Part II of this form, and any other wishes known to your agent. To the extent your wishes are unknown, health care decisions by your agent will conform as closely as possible to what you would choose under the circumstances. If your agent is unable to determine what you would choose, your agent will make health care decisions based on what your agent determines to be your best interest. In determining your best interest, your agent should consider your personal values. The agent should consider these and other factors if applicable:

- Your personal, philosophical, religious, and ethical values,
- Your likelihood of regaining decision-making capacity,
- The likelihood of your death,
- The treatment's burdens on and benefits to your future,
- Reliable oral or written statements previously made by you, including, but not limited to, statements made to family members, friends, health care providers or religious leaders.

COMPLETING PART II: PRIORITIES AND INSTRUCTIONS

If you are an adult who is mentally competent and have decision-making capacity, you have the right to accept or refuse medical treatment, if refusing is not contrary to existing public health laws. By completing this form, you are giving advance instructions for medical treatment. These instructions will only become effective during times when your physician or Advanced Practice Clinician determines that you lack the capacity to make medical decisions.

The section **My Health Care Priorities** gives your Agent and your medical care team helpful guidance about your care goals. Read through all the priorities and choose the level of importance you give for each priority. There is space at the bottom for additional information. Having a meaningful conversation with your Agent about the values as well as your thoughts and feelings behind your choices is highly recommended.

The section **Specific Instructions** gives your Agent and your medical care team directions that you want them to follow regarding the provision of life sustaining treatments, including CPR, nutrition, and other medical care.

The section **Relief from Pain** records your preference for treating pain at the end of life.

The section **Optional Special Powers and Guidance** allows you to have a voice in what and how certain decisions about your care are made. Decisions include admission to mental health facilities, long-term care placements, access to information, and how you want your Agent to act on your instructions.

The section **Other Medical Instructions** allows you to include instructions for any other medical conditions or treatments.

The section **Goals of Care** provides space for you to share any guiding values or goals of care that would be helpful to your providers. For example, you could say that you want to be kept comfortable or that you would like to be transferred home if possible. You could ask that medical efforts be made to allow distant family or friends to visit or communicate with you.

In the **Other Needs and Values** section, you name people or activities that would be personally important. For example, you can request the presence of a religious leader or list other spiritual care needs. You could request privacy with limited visitation by certain family and friends or encourage your loved ones to gather in support of each other.

Advance Health Care Directive

Of

NAME:_____ **DATE OF BIRTH:**_____

PART I: POWER OF ATTORNEY FOR HEALTH CARE

DESIGNATION OF AGENT

I designate as my agent to make health care decisions for me:

_____

(Name)

_____

(Street, City, State, Zip Code)

_____

(Telephone)

ALTERNATE AGENT

If my agent is not living, willing or able, or reasonably available to make health care decisions for me, then I designate as my **Alternate Agent**:

_____

(Name)

_____

(Street, City, State, Zip Code)

_____

(Telephone)

AGENT'S AUTHORITY: I grant to my agent full authority to make decisions for me regarding my health care, provided that, by exercising this authority, my agent shall follow my instructions as stated in this document or otherwise known to my agent.

WHEN MY AGENG'S AUTHORITY BECOMES EFFECTIVE: my agent's authority becomes effective when my attending physician or Advanced Practice Clinician determines that I lack the capacity to make my own health care decisions.

EFFECT OF A COPY: a copy of this form has the same effect as the original. I understand the purpose and effect of this document

PART II. INSTRUCTIONS FOR HEALTH CARE

MY HEALTH CARE PRIORITIES

When making decisions about the goals of my care, consider the level of importance I hold for each of these goals:

Staying alive as long as possible, even if I have substantial physical limitations is:
(___) Very Important
(___) Somewhat Important
(___) Not Important

Staying alive as long as possible, even if I have substantial mental limitations is:
(___) Very Important
(___) Somewhat Important
(___) Not Important

Being free from pain is:
(___) Very Important
(___) Somewhat Important
(___) Not Important

Being independent is:
(___) Very Important
(___) Somewhat Important
(___) Not Important

Having my agent talk with my family before making care decisions is:
(___) Very Important
(___) Somewhat Important
(___) Not Important

Having my agent talk with my friends before making care decisions is:
(___) Very Important
(___) Somewhat Important
(___) Not Important

Other Priorities:

_____

_____

_____

_____

SPECIFIC INSTRUCTIONS ABOUT LIFE SUSTAINING TREATMENT

I give these specific instructions to be followed by my Physician or Advanced Practice Clinician:

LIFE-SUSTAINING TREATMENT is any treatment attempting to keep me alive but not needed for comfort or any other purpose. Treatments can include but are not limited to Cardio-Pulmonary Resuscitation (CPR), the use of a breathing machine (Intubation), and Kidney Dialysis. (Check or initial all that apply.)

(___) Always be given to me (If you select this choice, do not select other choices in this "Life Sustaining Treatment" section.)
(___) Not be given to me if I have a condition that is not curable and is expected to cause my death soon, even if treated.
(___) Not be given to me if I am unconscious, and I am not expected to be conscious again.
(___) Not be given to me if I have a medical condition from which I am not expected to recover that prevents me from communicating with people I care about, caring for myself, and recognizing family and friends.
(___) Other:

_____

_____

_____

FOOD AND LIQUIDS: If I can't swallow and staying alive requires me to get food or liquids through a tube or other means for the rest of my life, then food or liquids should (check or initial all that apply):

(___) Always be given to me (If you select this choice, do not select other choices in this "Life Sustaining Treatment" section.)
(___) Not be given to me if I have a condition that is not curable and is expected to cause my death soon, even if treated.
(___) Not be given to me if I am unconscious, and I am not expected to be conscious again.
(___) Not be given to me if I have a medical condition from which I am not expected to recover that prevents me from communicating with people I care about, caring for myself, and recognizing family and friends.
(___) Other:

_____

_____

_____

RELIEF FROM PAIN

I direct that in all circumstances; I be given all medically appropriate care necessary to alleviate or manage my pain. If I am determined to be at the end of my life and in pain, providing care that will keep me comfortable but likely to shorten my life should (check or initial all that apply.)

(___) Always be given to me (If you select this choice, do not select other choices in this "Life Sustaining Treatment" section.)
(___) Not be given to me if I have a condition that is not curable and is expected to cause my death soon, even if treated.
(___) Not be given to me if I am unconscious, and I am not expected to be conscious again.
(___) Not be given to me if I have a medical condition from which I am not expected to recover that prevents me from communicating with people I care about, caring for myself, and recognizing family and friends.
(___) Other:

_____

_____

_____

OPTIONAL SPECIAL POWERS AND GUIDANCE

My agent can do the following ONLY if I have checked or initialed them:

(___) Admit me as a voluntary patient to a facility for mental health treatment for up to _____ days. (Write in the number of days.)

(___) Place me in a nursing home for more than 100 days, even if my needs can be met somewhere else, I am not terminally ill, and I object.

My agent may obtain, examine, and share information about my health needs and health care if I am not able to make decisions for myself. When checked or initialed below, my agent may also do so at any time my agent thinks it will help me.

(___) I give my agent permission to obtain, examine, and share information about my health needs and health care whenever my agent thinks it will help me.

(___) I give my agent permission to be flexible in applying these instructions if my agent thinks it would be in my best interest based on what my agent know about me.

OTHER MEDICAL INSTRUCTIONS

I give these additional instructions for my medical care:

_____

_____

_____

_____

GOALS OF CARE

I ask that these personal values and medical goals of care be used to guide my plan of care:

_____

_____

_____

_____

OTHER NEEDS AND VALUES

I ask that these personal needs and values be used to guide my plan of care:

_____

_____

_____

_____

INFORMATION FOR THE AGENT OR AGENTS

As the agent, you can make decisions following the instructions given in this document and any other instructions you have received from the patient. If you do not know what the patient wants, make the decision that you think is in the patient's best interest. You can consider the patient's values, preferences, and goals of care. You can receive the patient's health information only while the patient lacks capacity to make decisions, unless the patient has indicated otherwise under "Optional Powers and Guidance."

SIGNATURES

My name and signature

_____ _____ _____
(Print) (Signature) (Date)

_____
(Street, City, State, Zip Code)

Witness name and signature

_____ _____ _____
(Print) (Signature) (Date)

_____
(Street, City, State, Zip Code)

STATEMENT OF WITNESS

SIGNED AND DECLARED by the above-named declarant as and for this person's written declaration under 16 Del.C. §§ 2508(d), in my presence, who in this person's presence, at this person's request, and in the presence of each other, have written my name as witness, and state:

I am present at the time when this person signs the Power of Attorney for Health Care and/or the advance directives representing their intentions.

I am at least 18 years of age.

I reasonably believe that the act of this person to create the power of attorney is voluntary and knowing.

I am not the agent appointed by this person.

I am not the agent's spouse, domestic partner, or cohabitant.

If this person is a resident of a sanitorium, rest home, nursing home, boarding home, or related institution, I am not the owner, operator, employee or a contractor of the resident institution.

NOTARY (Witness by a notary is optional. Beebe notaries are ineligible.)

Sworn and subscribed to me on this _____ day of _____.

My term expires: _____ _____
(Notary Signature)